RIDGEFIELD PARK PUBLIC SCHOOLS
712 Lincoln Avenue, Ridgefield Park, NJ 07660
Tel: 201-807-2640 // www.rpps.net

Welcome to the Ridgefield Park Public School District

PLEASE NOTE:

The following is a list of documents that must be presented in order to enroll a student in the Ridgefield Park Public School System. All items listed below **MUST BE SUBMITTED** or your registration will not be processed.

- ☐ Application for Enrollment
- ☐ Birth Certificate
- ☐ Parent/Guardian ID
- ☐ Affirmation of Residency
  a. **Own -** Deed, Property Tax Records, and/or Mortgage Statement
  b. **Rent -** Current Lease with Landlord's contact information OR Landlord Affidavit completed and notarized with Landlord's contact information
  c. **Utility Bill -** Must be current.
- ☐ Transfer Card from the previous school district.
- ☐ Special Education Students: If your child has an IEP or 504 you must include the most recent IEP from the current school district.
- ☐ Medical Records
  a. **Elementary Students (K-6)**: Universal Health Record Form completed by a physician along with immunization records.
  b. **High School Students (7-12)**: Preparticipation Physical Evaluation History Form along with immunization records.

ADDITIONAL INFORMATION REQUIRED:

High School students must provide academic records (transcripts) from the previous school showing course work and credits completed. If the student is entering the 9th grade, you must show proof that the student has completed the 8th grade. If coming from a New Jersey school, please provide NJASK and HSPA scores if available.

Custody or Guardianship paperwork from the Bergen County Courthouse Surrogate Court must be presented when a student is not living with the parent.

Once you have completed the online registration application you will be contacted by the district.

Should you have any questions prior to or after completing the online registration please contact kthompson@rpschools.net.

All registration packages will be reviewed within 48 hours of confirmation.

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DATE:_____ **GRADE LEVEL**:_____

STUDENT INFORMATION:

LAST NAME: _____

FIRST NAME: _____ **MIDDLE NAME:** _____

BIRTH INFORMATION: IF BORN IN THE US

DATE OF BIRTH: _____ **BIRTH CITY:** _____ **BIRTH STATE:** _____

BIRTH INFORMATION: IF BORN OUTSIDE THE US

DATE OF BIRTH: _____ **BIRTH CITY/COUNTRY:** _____

DATE OF ENTRY IN U.S.: _____

GENDER:	**ETHNICITY**: DATA IS REQUIRED FOR ALL NJ PUBLIC SCHOOLS	
☐ MALE	☐ HISPANIC OR LATINO	
☐ FEMALE	☐ NOT HISPANIC OR LATINO	
☐ NON/BINARY UNDESIGNATED	**RACE**:	
BIRTH GENDER:	☐ WHITE	☐ ASIAN
☐ MALE	☐ BLACK (AFRICAN AMERICAN)	☐ NATIVE HAWAIIAN/PACIFIC ISLANDER
☐ FEMALE	☐ AMERICAN INDIAN/ALASKAN	☐ OTHER: _____

LEGAL RESIDENCE:

☐ OWN ☐ RENT ☐ OTHER _____

ADDRESS: _____ **APT #:** _____

CITY: _____ **STATE:** _____ **ZIP CODE:** _____

HAS YOUR CHILD EVER BEEN EVALUATED FOR SPECIAL EDUCATION SERVICES?

☐ YES ☐ NO

☐ IEP	☐ IFSP	☐ ISP	☐ 504	☐ EVALUATIONS
☐ DOCTOR'S NOTE		☐ TEACHER/SCHOOL CORRESPONDENCE		☐ OTHER: PLEASE SUPPLY

MILITARY CONNECTED INFORMATION:

☐ ACTIVE DUTY – DEPENDENT OF AN ACTIVE FULL TIME MEMBER OF THE ARMED FORCES (ARMY, NAVY, MARINE, AIR FORCE OR COAST GUARD
☐ NOT MILITARY CONNECTED

PREVIOUS SCHOOL INFORMATION:

NAME:	
CITY/STATE:	
GRADE LEVEL:	**DATES ATTENDED:**

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DATE:_____ **GRADE LEVEL**:_____

STUDENT NAME: _____

PARENT/GUARDIAN INFORMATION:

GUARDIAN 1:

NAME:		**RELATIONSHIP:**
ADDRESS:		**APT #:**
CELL PHONE:	**CELL PHONE CARRIER:**	**HOME PHONE:**
EMAIL:		

GUARDIAN 2:

NAME:		**RELATIONSHIP:**
ADDRESS:		**APT #:**
CELL PHONE:	**CELL PHONE CARRIER:**	**HOME PHONE:**
EMAIL:		

SIBLING(S) ATTENDING THE RIDGEFIELD PARK SCHOOL DISTRICT:

NAME:	**SCHOOL**: PLEASE CIRCLE ONE	**GRADE**:
	RP JR/SR HS / ROOSEVELT / GRANT / LINCOLN	
	RP JR/SR HS / ROOSEVELT / GRANT / LINCOLN	
	RP JR/SR HS / ROOSEVELT / GRANT / LINCOLN	
	RP JR/SR HS / ROOSEVELT / GRANT / LINCOLN	
	RP JR/SR HS / ROOSEVELT / GRANT / LINCOLN	
	RP JR/SR HS / ROOSEVELT / GRANT / LINCOLN	

ACKNOWLEDGEMENT:

I certify that the information made by me is true, I am aware that if any of the foregoing statements made by me are false, I am subject to punishment under the law and may result in financial responsibility for school attendance.

PRINT NAME: _____

SIGNATURE: _____ DATE: _____

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ACADEMIC RECORDS REQUEST FORM

Grant School	Lincoln School	Roosevelt School	RPJRSRHS	Office of Special Services
104 Henry Street	712 Lincoln Avenue	508 Teaneck Road	One Ozzie Nelson Drive	98 Central Avenue
201-641-0441	201-994-1830	201-440-0808	201-440-1440	201-807-2650

Date: _____

The child named below has enrolled in one of our schools. The parent/guardian has authorized that the following records should be sent to the school circled above as soon as possible:

- ☐ Academic (including report card, transcript, standardized test scores, I.E.P.)
- ☐ Attendance
- ☐ Disciplinary
- ☐ Medical/Health
- ☐ Confidential

Full name of previous school: _____
Street Address: _____
City/State/Zip: _____
Telephone No.: _____
Fax No.: _____
Contact Email: _____

Thank You for your cooperation.

I hereby give permission to release all academic, attendance, health, disciplinary, and any confidential school records to the school circled above for:

Child's Name: _____

Current Grade Level: _____

Parent/Guardian Name (Print): _____

Parent/Guardian Signature: _____

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SPECIAL EDUCATION MEDICAID INITIATIVE (SEMI)

RIDGEFIELD PARK SCHOOL DISTRICT:

Our school district is participating in the Special Education Medicaid Initiative (SEMI) program that allows school districts to bill Medicaid for services that are provided to students.

In accordance with the Family Educational Rights and Privacy Act, 34 CFR §99.30 and Section 617 of the IDEA Part B, consent requirements in 34 CFR §300.622 require a one-time consent before accessing public Benefits.

This consent establishes that your child's personally identifiable information, such as student records or information about services provided to your child, including evaluations and services as specified in my child's Individualized Education Program (IEP) (occupational therapy, physical therapy, speech therapy, psychological counseling, audiology, nursing and specialized transportation,) may be disclosed to Medicaid and the Department of the Treasury for the purpose of receiving Medicaid reimbursement at the school District.

As parent/guardian of the child named below, I give permission to disclose information as described above and I understand and agree that Medicaid may access my child's or my public benefits or public insurance to pay for special education or related services under Part 300 (services under the IDEA). I understand that the school district is still required to provide services to my child pursuant to his or her IEP, regardless of my Medicaid eligibility status or willingness to consent for SEMI billing

I understand that billing for these services by the district does not impact my ability to access these services for my child outside of the school setting, nor will any cost be incurred by my family including co-pays, deductibles, loss of eligibility or impact on lifetime benefits.

Child's Name: _____

Date of Birth: _____

Parent/Guardian Signature: _____

Date: _____

I give consent to bill for SEMI:

- ☐ YES
- ☐ NO

This consent can be revoked at any time by contacting your child's Case Manager, or the administrator at your child's school, in writing.

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Home Language Survey

Purpose: The home language survey is used solely to offer appropriate educational services (U.S. ED EL Toolkit, Chapter 1). This survey is the first of three steps to identify whether or not a student is eligible to be identified as an English language learner (ELL). "Home" is defined as a student's current place of Residence.

Student Information:

Student Name: _____

Date of Birth (YYYYMMDD): _____

Current Address: _____

Survey Questions:

1.) List all languages used in the student's home.

_____

2.) Was the first language used by the student a language other than English?

_____ No _____Yes

3.) Does the student speak or understand a language other than English?

_____ No _____Yes

4.) When interacting with others at home (example: parents, guardians, siblings), does the student understand or use a language other than English **most of the time**?

_____ No _____Yes

5.) When interacting with others outside the home (example: friends, caregivers), does the student understand or use a language other than English **most of the time**?

_____ No _____Yes

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DATE: _____

MEDICAL HISTORY FORM

CHILD'S NAME: _____
LAST FIRST MIDDLE

DATE OF BIRTH: _____/_____/_____ **AGE: _____**

Please complete the child's health history below.

DIAGNOSIS	YES	NO	DATE OF DIAGNOSIS	TREATMENT AND/OR RESTRICTIONS
ASTHMA				
BLOOD DISORDER				
CHICKEN POX				
DIABETES				
HEAD INJURY				
HEART PROBLEM				
SEIZURE				
SKIN CONDITION				
SPEECH/LANGUAGE				
URINARY PROBLEM				
VISION/GLASSES				

Current Medications: Please include the name of the medicine, the dosage, time, and reason for use.

NAME OF MEDICINE	DOSAGE	TIME	REASON

Hospitalizations for illness or surgery: Please include diagnosis and year.

HOSPITALIZATION REASON	DIAGNOSIS	YEAR

I GIVE MY PERMISSION FOR THIS INFORMATION TO BE SHARED WITH APPROPRIATE SCHOOL STAFF.

PARENT/GUARDIAN NAME:_____

PARENT/GUARDIAN SIGNATURE: _____

RELATIONSHIP TO CHILD: _____

DATE: _____

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DATE: _____

ALLERGY RECORD FORM

CHILD'S NAME: _____
LAST FIRST MIDDLE

DATE OF BIRTH: _____/_____/_____ **AGE:** _____

If your child has **NO** allergies/reactions please check here ☐ and sign below.

ITEM	YES	NO	TYPE OF REACTION	MEDICATION TAKEN	ACTIONS TO BE TAKEN
DAIRY PRODUCTS					
EGGS					
PEANUTS					
OTHER FOODS PLEASE LIST BELOW					
BEES					
OTHER ANIMALS PLEASE LIST BELOW					
PENICILLIN					
ERYTHROMYCIN					
OTHER MEDS PLEASE LIST BELOW					
SEASONAL ALLERGIES					
OTHER ALLERGIES PLEASE LIST BELOW					

ADDITIONAL INFORMATION

OTHER FOOD:

FOOD	TYPE OF REACTION	MEDICATION TAKEN	ACTIONS TO BE TAKEN

OTHER ANIMALS:

ANIMAL	TYPE OF REACTION	MEDICATION TAKEN	ACTIONS TO BE TAKEN

OTHER MEDICATION:

MEDICATION	TYPE OF REACTION	MEDICATION TAKEN	ACTIONS TO BE TAKEN

OTHER ALLERGIES:

ALLERGIES	TYPE OF REACTION	MEDICATION TAKEN	ACTIONS TO BE TAKEN

PARENT/GUARDIAN SIGNATURE: _____ **DATE:** _____

RELATIONSHIP TO CHILD: _____

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DATE: _____

MEDICATION FORM

CHILD'S NAME: _____
LAST FIRST MIDDLE

DATE OF BIRTH: _____/_____/_____ **AGE:** _____

PARENT/GUARDIAN NAME: _____

RELATIONSHIP TO CHILD: _____

A child must not bring to school any prescribed or over-the-counter medication...not one single dose! Any such products must be brought to the school nurse by a parent/guardian with directions for use from a physician. Only a a school nurse may administer the medication.

By my signature, I certify that my child does not need to take any prescribed or over-the-counter medication during the school day.

PARENT/GUARDIAN SIGNATURE: _____

DATE: _____

There are few exceptions to this rule:
Permission may be granted to your child for self-administration of medication for asthma or other potentially life threatening conditions if the school receives written permission from a parent/guardian and authorization by a physician. Even in this case, we may require that the medication be self-administered in the presence of the school nurse.

By my signature below I give permission for my child to self-administer the medication indicated by the physician. I understand that Ridgefield Park Public Schools shall incur no liability as a result of any injury arising from the self-administration of medication by my child and I shall indemnify and hold harmless the Ridgefield Park Board of Education and its employees and agent against any claims arising as a result of the self administration of medication by my child.

PARENT/GUARDIAN SIGNATURE: _____ **DATE:** _____

RELATIONSHIP TO CHILD: _____

TO BE COMPLETED BY PHYSICIAN'S OFFICE:

Diagnosis	Name of Medication	Form of Medication	Dose	Time	How soon the dose can be repeated	List of significant side effects	Length of time this treatment is recommended

☐ **The above mentioned child has asthma and/or other life threatening condition and has been instructed in and is capable of self-administering the medication noted above.**

Physician's Signature and Stamp: **PLACE STAMP HERE**

Physician's Name: _____

SIGNATURE: _____

ADDRESS: _____

_____

TELEPHONE: _____

ATTENTION PARENT/GUARDIAN: The preparticipation physical examination (page 3) must be completed by a health care provider who has completed the Student-Athlete Cardiac Assessment Professional Development Module.

PREPARTICIPATION PHYSICAL EVALUATION
HISTORY FORM

(Note: This form is to be filled out by the patient and parent prior to seeing the physician. The physician should keep a copy of this form in the chart.)

Date of Exam _____

Name _____ Date of birth _____

Sex _____ Age _____ Grade _____ School _____ Sport(s) _____

Medicines and Allergies: Please list all of the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking

_____

_____

_____

Do you have any allergies? ☐ Yes ☐ No If yes, please identify specific allergy below.
☐ Medicines ☐ Pollens ☐ Food ☐ Stinging Insects

Explain "Yes" answers below. Circle questions you don't know the answers to.

GENERAL QUESTIONS	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?		
2. Do you have any ongoing medical conditions? If so, please identify below: ☐ Asthma ☐ Anemia ☐ Diabetes ☐ Infections Other: _____		
3. Have you ever spent the night in the hospital?		
4. Have you ever had surgery?		
HEART HEALTH QUESTIONS ABOUT YOU	**Yes**	**No**
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?		
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
7. Does your heart ever race or skip beats (irregular beats) during exercise?		
8. Has a doctor ever told you that you have any heart problems? If so, check all that apply: ☐ High blood pressure ☐ A heart murmur ☐ High cholesterol ☐ A heart infection ☐ Kawasaki disease Other: _____		
9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)		
10. Do you get lightheaded or feel more short of breath than expected during exercise?		
11. Have you ever had an unexplained seizure?		
12. Do you get more tired or short of breath more quickly than your friends during exercise?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	**Yes**	**No**
13. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)?		
14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?		
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?		
16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?		
BONE AND JOINT QUESTIONS	**Yes**	**No**
17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?		
18. Have you ever had any broken or fractured bones or dislocated joints?		
19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?		
20. Have you ever had a stress fracture?		
21. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism)		
22. Do you regularly use a brace, orthotics, or other assistive device?		
23. Do you have a bone, muscle, or joint injury that bothers you?		
24. Do any of your joints become painful, swollen, feel warm, or look red?		
25. Do you have any history of juvenile arthritis or connective tissue disease?		

MEDICAL QUESTIONS	Yes	No
26. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
27. Have you ever used an inhaler or taken asthma medicine?		
28. Is there anyone in your family who has asthma?		
29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
30. Do you have groin pain or a painful bulge or hernia in the groin area?		
31. Have you had infectious mononucleosis (mono) within the last month?		
32. Do you have any rashes, pressure sores, or other skin problems?		
33. Have you had a herpes or MRSA skin infection?		
34. Have you ever had a head injury or concussion?		
35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
36. Do you have a history of seizure disorder?		
37. Do you have headaches with exercise?		
38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
39. Have you ever been unable to move your arms or legs after being hit or falling?		
40. Have you ever become ill while exercising in the heat?		
41. Do you get frequent muscle cramps when exercising?		
42. Do you or someone in your family have sickle cell trait or disease?		
43. Have you had any problems with your eyes or vision?		
44. Have you had any eye injuries?		
45. Do you wear glasses or contact lenses?		
46. Do you wear protective eyewear, such as goggles or a face shield?		
47. Do you worry about your weight?		
48. Are you trying to or has anyone recommended that you gain or lose weight?		
49. Are you on a special diet or do you avoid certain types of foods?		
50. Have you ever had an eating disorder?		
51. Do you have any concerns that you would like to discuss with a doctor?		
FEMALES ONLY		
52. Have you ever had a menstrual period?		
53. How old were you when you had your first menstrual period?		
54. How many periods have you had in the last 12 months?		

Explain "yes" answers here

_____

_____

_____

_____

_____

_____

_____

_____

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of athlete _____ Signature of parent/guardian _____ Date _____

HE0503 9-2681/0410

New Jersey Department of Education 2014; Pursuant to P.L.2013, c.71

Preparticipation Physical Evaluation

THE ATHLETE WITH SPECIAL NEEDS: SUPPLEMENTAL HISTORY FORM

Date of Exam _____

Name _____ Date of birth _____

Sex _____ Age _____ Grade _____ School _____ Sport(s) _____

1. Type of disability		
2. Date of disability		
3. Classification (if available)		
4. Cause of disability (birth, disease, accident/trauma, other)		
5. List the sports you are interested in playing		
	Yes	**No**
6. Do you regularly use a brace, assistive device, or prosthetic?		
7. Do you use any special brace or assistive device for sports?		
8. Do you have any rashes, pressure sores, or any other skin problems?		
9. Do you have a hearing loss? Do you use a hearing aid?		
10. Do you have a visual impairment?		
11. Do you use any special devices for bowel or bladder function?		
12. Do you have burning or discomfort when urinating?		
13. Have you had autonomic dysreflexia?		
14. Have you ever been diagnosed with a heat-related (hyperthermia) or cold-related (hypothermia) illness?		
15. Do you have muscle spasticity?		
16. Do you have frequent seizures that cannot be controlled by medication?		

Explain "yes" answers here

_____

_____

_____

_____

_____

Please indicate if you have ever had any of the following.

	Yes	**No**
Atlantoaxial instability		
X-ray evaluation for atlantoaxial instability		
Dislocated joints (more than one)		
Easy bleeding		
Enlarged spleen		
Hepatitis		
Osteopenia or osteoporosis		
Difficulty controlling bowel		
Difficulty controlling bladder		
Numbness or tingling in arms or hands		
Numbness or tingling in legs or feet		
Weakness in arms or hands		
Weakness in legs or feet		
Recent change in coordination		
Recent change in ability to walk		
Spina bifida		
Latex allergy		

Explain "yes" answers here

_____

_____

_____

_____

_____

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of athlete _____ Signature of parent/guardian _____ Date _____

New Jersey Department of Education 2014; Pursuant to P.L.2013, c.71

NOTE: The preparticiaption physical examination must be conducted by a health care provider who 1) is a licensed physician, advanced practice nurse, or physician assistant; and 2) completed the Student-Athlete Cardiac Assessment Professional Development Module.

PREPARTICIPATION PHYSICAL EVALUATION
PHYSICAL EXAMINATION FORM

Name _____ Date of birth _____

PHYSICIAN REMINDERS

1. **Consider additional questions on more sensitive issues**
   - **Do you feel stressed out or under a lot of pressure?**
   - **Do you ever feel sad, hopeless, depressed, or anxious?**
   - **Do you feel safe at your home or residence?**
   - **Have you ever tried cigarettes, chewing tobacco, snuff, or dip?**
   - **During the past 30 days, did you use chewing tobacco, snuff, or dip?**
   - **Do you drink alcohol or use any other drugs?**
   - **Have you ever taken anabolic steroids or used any other performance supplement?**
   - **Have you ever taken any supplements to help you gain or lose weight or improve your performance?**
   - **Do you wear a seat belt, use a helmet, and use condoms?**
2. **Consider reviewing questions on cardiovascular symptoms (questions 5–14).**

EXAMINATION		
Height Weight ☐ Male ☐ Female		
BP / (/) Pulse Vision R 20/ L 20/ Corrected ☐ Y ☐ N		
MEDICAL	**NORMAL**	**ABNORMAL FINDINGS**
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency)		
Eyes/ears/nose/throat • Pupils equal • Hearing		
Lymph nodes		
Heart[a] • Murmurs (auscultation standing, supine, +/- Valsalva) • Location of point of maximal impulse (PMI)		
Pulses • Simultaneous femoral and radial pulses		
Lungs		
Abdomen		
Genitourinary (males only)[b]		
Skin • HSV, lesions suggestive of MRSA, tinea corporis		
Neurologic[c]		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand/fingers		
Hip/thigh		
Knee		
Leg/ankle		
Foot/toes		
Functional • Duck-walk, single leg hop		

[a]Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.
[b]Consider GU exam if in private setting. Having third party present is recommended.
[c]Consider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion.

☐ Cleared for all sports without restriction

☐ Cleared for all sports without restriction with recommendations for further evaluation or treatment for _____

_____

☐ Not cleared

- ☐ Pending further evaluation
- ☐ For any sports
- ☐ For certain sports _____

Reason _____

Recommendations _____

_____

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, a physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of physician, advanced practice nurse (APN), physician assistant (PA) (print/type)_____ Date of exam _____

Address _____ Phone _____

Signature of physician, APN, PA _____

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PREPARTICIPATION PHYSICAL EVALUATION
CLEARANCE FORM

Name _____ Sex ☐ M ☐ F Age _____ Date of birth _____

☐ Cleared for all sports without restriction

☐ Cleared for all sports without restriction with recommendations for further evaluation or treatment for _____

_____

☐ Not cleared

- ☐ Pending further evaluation
- ☐ For any sports
- ☐ For certain sports _____

  Reason _____

Recommendations _____

_____

_____

_____

_____

_____

EMERGENCY INFORMATION

Allergies _____

_____

_____

_____

_____

_____

Other information _____

_____

_____

_____

_____

HCP OFFICE STAMP

SCHOOL PHYSICIAN:

Reviewed on _____
(Date)

Approved _____ Not Approved _____

Signature:_____

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of physician, advanced practice nurse (APN), physician assistant (PA) _____ Date _____

Address _____ Phone _____

Signature of physician, APN, PA _____

Completed Cardiac Assessment Professional Development Module

Date_____ Signature_____

New Jersey Department of Education 2014; Pursuant to P.L.2013, c.71